

## MEDICAL APPROVAL FORM

NAME OF PARTICIPANT: \_\_\_\_\_ DATE \_\_\_\_\_

PHONE #: \_\_\_\_\_

The fitness center at West Hartford Senior Center provides a number of health/fitness activities, programs and services for the apparently healthy individual. We would appreciate it if you would signify your approval for their participation in this program by completing the following questions.

1. Has the patient experienced any of the following symptoms of CVD?

\_\_\_\_\_ Palpitations or abnormal heart rhythms

\_\_\_\_\_ Chest pain or pressure (angina type)

\_\_\_\_\_ Dizziness or faintness upon exertion

If so, please explain \_\_\_\_\_

\_\_\_\_\_

2. Does the patient have any of the following CVD risk factors?

\_\_\_\_\_ Hypertension

\_\_\_\_\_ Hyperglycemia or diabetes mellitus

\_\_\_\_\_ Hypercholesterolemia of elevated blood lipids

\_\_\_\_\_ Cigarette smoking

\_\_\_\_\_ Family history of heart disease

\_\_\_\_\_ Obesity

\_\_\_\_\_ Sedentary lifestyle

\_\_\_\_\_ Tension / stress

3. List any musculoskeletal injuries or problems, such as arthritis, that may be aggravated by exercise or that may limit an exercise program.

\_\_\_\_\_

\_\_\_\_\_

4. Please indicate any heart, fluid, blood pressure, seizure, diabetic or an other pertinent medications taken on a regular basis, and maximum heart rate not to exceed during exercise where applicable:

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Based on the preceding information, please indicate approval of the following exercises and equipment for use by filling in the appropriate boxes below.

\_\_\_\_\_ may participate in the following activities. Please use a (+) to indicate approval and a (o) to signify contraindicated.

- |                                  |                                |
|----------------------------------|--------------------------------|
| _____ flexibility                | _____ exercise bicycles        |
| _____ walking program            | _____ aerobics                 |
| _____ running /jogging           | _____ low-impact               |
| _____ Nordic Track ski simulator | _____ general swimming         |
| _____ calisthenics               | _____ lap swimming             |
| _____ water aerobics             | _____ free weights             |
| _____ resistance machines        | _____ stairmaster              |
| _____ sauna and whirlpool        | _____ elliptical cross trainer |
| _____ rowing machine             | _____ Nustep recumbent stepper |

Exceptions/ restrictions on above exercises \_\_\_\_\_

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Recommend participation on the fitness program:

Full \_\_\_\_\_ Limited \_\_\_\_\_ (Comments, recommendations)

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Physicians name (please print) \_\_\_\_\_

Signature \_\_\_\_\_ Phone \_\_\_\_\_